NOT CONTACTING OR COMPLYING WITH QCP

The QCP Penalty

When MAP is the primary medical plan, including primary coverage for specific benefits, and QCP is not contacted or does not certify . . .

- Overnight hospital admissions (including emergency admissions that last longer than 48 hours),
- Inpatient surgeries,
- Mandatory Outpatient Surgical Procedures performed on an inpatient basis, or
- Surgeries on the Mandatory Second Surgical Opinion List

. . . the QCP Penalty will be applied. This means that if you do not contact QCP or if you do not follow QCP's recommendations, your MAP payments will be reduced by $250 for each time you fail to comply with QCP requirements. **Therefore, more than one QCP Penalty may be applied for a single hospital confinement.** In addition, QCP Penalties will not apply to the deductible or out-of-pocket limit.

Loss Of Benefits

Whether MAP is your primary or secondary medical plan, and whether or not you or your dependents are Medicare eligible, QCP pre-certification is always required for coverage under the provisions for Alternate Benefits, inpatient mental and nervous care and private duty nursing; otherwise, there is **no coverage** for those expenses and they will not apply to the deductible or out-of-pocket limit.

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Remember, all decisions regarding your medical care are up to you and your doctor.

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ALTERNATE BENEFITS

The Alternate Benefits provide you with options to hospital stays and other medical care or treatments that are less intensive and less expensive. Alternate Benefits include coverage for:

- Home health care;
- Extended care/skilled nursing facilities;
- Birthing centers/nurse midwives;
- Hospice care;
- Partial hospitalization for a substance abuse rehabilitation program (page 53); and
- Expenses due to special arrangements or treatments when medically appropriate.

Should you, your family or your physician, etc., choose not to comply with QCP's recommendation concerning Alternate Benefits, MAP payments will be made only up to the following Plan limits:

- The current care as long as medically necessary, or
- The alternate care authorized by QCP.

Any charges in excess of these limits will be your responsibility.

If pre-certified by QCP, once you have met the deductible, 100% of the covered charges for Alternate Benefits will be paid by the Plan.

If not pre-certified by QCP, the Alternate Benefits are not considered covered expenses and, therefore, are not eligible at all for reimbursement under MAP. However, the decision to use an Alternate Benefit is up to you and your doctor.

INPATIENT MENTAL AND NERVOUS CARE

Benefits for inpatient mental and nervous care (which includes substance abuse care) are only available if pre-certified by QCP.

If QCP does not pre-certify an inpatient stay for mental and nervous treatment, the expenses are not covered at all by MAP and, therefore, are not eligible for reimbursement. However, the decision to use inpatient treatment for mental and nervous care is up to you and your doctor.

As for other benefits, mental and nervous confinements will be reviewed during the hospitalization to determine the portion of care that is medically necessary treatment versus that which is maintenance or custodial and not covered under MAP.

The Plan's specific benefit levels for mental and nervous care are explained in Section 9.

EMERGENCIES

In an emergency, QCP must be contacted within 48 hours if you are admitted to the hospital unless you are released in less than 48 hours.

If you are admitted to a non-PPO hospital but you live in a PPO area, QCP — with your doctor's input — will determine if a transfer to a PPO hospital is possible. If it is determined that a transfer is possible, benefits will be reduced if you choose not to move. When the arrangements are handled by QCP, the full cost of the transfer will be paid by MAP. **However, the decision to remain in the non-PPO hospital and pay the associated costs or to move to a PPO hospital is yours in consultation with your doctor.**

SECTION 7. HOSPITAL CARE BENEFITS

This Section outlines the most common hospital care expenses covered under MAP and the benefits for those expenses. If you have any questions about any hospital expenses not listed here, call QCP or Blue Cross and Blue Shield before proceeding with treatment to determine whether the charges would be covered.

INPATIENT HOSPITAL BENEFITS

MAP covers expenses for medically necessary hospital services. The percentage of covered hospital charges paid by MAP is determined by whether or not you:

- Use a Preferred Provider Organization (PPO) hospital;
- Live in a PPO area; and
- Are a Medicare-eligible participant.

Some of the hospital services covered include:

- Semi-private room and board rate;
- Private room when in a private-room-only hospital (90% of the most prevalent private room rate);
- Use of operating, delivery and recovery rooms plus special equipment;
- General nursing care;
- Laboratory tests and X-rays;
- Special diets;
- Physical therapy; and
- Administration of blood (page 62 for benefits for the cost of the blood itself).

You may call QCP for telephone numbers of PPO hospitals to obtain the names of physicians who have admitting privileges at those PPO hospitals.

For maximum MAP benefits, please keep in mind you must follow the Plan's QCP provisions described in the prior Section.

BENEFITS WHEN YOU, OR A DEPENDENT, ARE MEDICARE ELIGIBLE

MAP pays 100% of covered inpatient hospital charges, after the deductible, less the amount eligible for payment from Medicare (and any other coverage that is primary to MAP, as explained in Section 12).

The PPO hospital provisions of MAP do not affect you. However, you are encouraged to use a PPO hospital whenever possible.

BENEFITS WHEN YOU, OR A DEPENDENT, ARE NOT MEDICARE ELIGIBLE

If you, or a dependent, are not Medicare eligible, MAP pays inpatient hospital benefits for covered hospital charges, once the deductible is met, as follows. (For benefits for mental and nervous care, including substance abuse care, see Section 9.)

- When you live in a PPO area (see the definition of "PPO area" on page 9), MAP pays:
  - — 100% of covered inpatient hospital charges from a PPO hospital, and
  - — 90% of the PPO area payment allowance for covered inpatient hospital charges from a non-PPO hospital. Any charges above the PPO area payment allowance are not covered expenses and do not count toward your deductible or the individual out-of-pocket limit. Therefore, the amount you pay could be substantial — as much as 40% or more of the non-PPO hospital charges.
- When you do not live in a PPO area, MAP pays 100% of covered inpatient hospital charges.

An Example

Assume you live in a PPO area, you have already met your deductible and QCP pre-certified a 4-day stay.

For a PPO hospital stay, all of the covered hospital charges are paid in full and you pay nothing.

For a non-PPO hospital stay, assume:

- You are not Medicare eligible;
- The non-PPO hospital charges $3,500 for your stay; and
- The PPO area payment allowance (PA) is $3,200.

Here's what MAP would pay for this non-PPO stay.

Non-PPO Hospital Charges				$3,500
MAP Would Pay	→	90% of PA	→	90% x $3,200 = $2,880
You Would Pay	→	Hospital charge minus benefit	→	$3,500 - $2,880 = $ 620
Applies To Out-Of-Pocket Limit	→	PA minus benefit	→	$3,200 - $2,880 = $ 320
Does Not Apply To Out-Of-Pocket Limit	→	Hospital charge minus PA	→	$3,500 - $3,200 = $ 300

In this example, you would pay $620. $320 is the remaining 10% of PA covered charges and applies toward the out-of-pocket limit; the $300 above PA is not a covered expense and does not apply to the out-of-pocket limit.

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Remember, as always, the choice about which hospital to use is up to you and your doctor — you make the decision each time you require hospitalization.

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SPECIAL LIMITATIONS

Treatment Of Mental And Nervous Conditions

For partial hospitalization for substance abuse or treatment of an inpatient mental and nervous condition, QCP must pre-certify the stay in order for the expenses to be covered. In addition, there are other special limitations on mental and nervous care benefits. Refer to Section 9 for more information.

Diagnostic X-Rays/Laboratory Tests, Physical Therapy

If you enter a hospital on an inpatient basis primarily for diagnostic X-rays/laboratory tests or physical therapy, no benefits will be paid toward your room and board charges. The room and board charges are not covered expenses and will not apply toward your deductible or the out-of-pocket limit since this type of care can be provided on an outpatient basis.

The expenses for services other than room and board will be covered at 90% of R&C after the deductible requirement has been satisfied. You will pay the difference.

Weekend Admissions

Weekend room and board charges will not be pre-certified and will not be covered by MAP when you are admitted to the hospital on a Friday or Saturday for a non-emergency condition unless, on the day you are admitted:

- You have surgery, or
- You have a condition that requires hospitalization for medically required tests with surgery performed on the following day.

Rehabilitative/Custodial Expenses

Hospital room and board and ancillary charges are not covered when the admission is custodial or primarily for rehabilitative purposes which could be provided on an outpatient basis.

Dental Care

Hospitalization for dental care is covered only when:

- Confinement results from accidental bodily injury, or
- A physician, other than a dentist, pre-certifies through QCP that hospitalization is necessary due to a non-dental organic impairment to safeguard the life or health of the patient.

No hospitalization benefits are paid for surgical removal of impacted teeth unless there is an underlying medical condition requiring confinement.

OUTPATIENT HOSPITAL BENEFITS

Covered charges for non-emergency services from an ambulatory surgical facility or an outpatient department of a hospital are paid as follows.

- PPO hospital benefits are paid at 100% of covered charges.
- If you live in a PPO area and use a non-PPO hospital, benefits are paid at:
  - — 90% of PA, unless the charges are for pre-admission or pre-surgical X-rays or tests, or
  - — 100% of R&C for pre-admission or pre-surgical X-rays or tests (criteria on page 38).

- If you live outside a PPO area and use a non-PPO hospital, benefits are paid at:
  - — 90% of R&C, unless the charges are for pre-admission or pre-surgical X-rays or tests or for outpatient surgery;
  - — 100% of R&C for pre-admission or pre-surgical X-rays or tests; or
  - — 100% of R&C for outpatient surgery.
- If you are a Medicare-eligible participant, benefits will be paid at 100% of covered charges. However, you are encouraged to use a PPO hospital whenever possible.

The deductible is not required for the following:

- Outpatient surgery;
- Accidental injury and sudden/serious illness when treated within 72 hours;
- Pre-admission or pre-surgical X-rays or tests;
- Radiation/chemotherapy;
- Electroshock therapy;
- Routine pap smears (lab fee); or
- Routine mammography screenings (covered effective January 1, 1991).

To be considered pre-surgical tests for outpatient surgery or pre-admission tests, the following criteria must be met:

- The tests must be necessary and consistent with the diagnosis and treatment of the condition;
- The patient is physically present for the test;
- The tests are not performed to determine whether hospital care is necessary;

- The admission or scheduled outpatient surgery is not cancelled or postponed except as a result of a second surgical opinion or other medical reason; and
- In the case of pre-admission tests, a hospital bed is reserved before the tests are performed and the admission date is such that the tests would be medically valid for the treatment.

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Remember, with regard to MAP's special limitations for Plan benefits, the decision as to the method or place of your treatment is always up to you and your physician.

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SECTION 8. PHYSICIAN/SURGEON CARE BENEFITS

OFFICE AND HOSPITAL VISITS

For non-occupational illness or injury, physician charges for office visits and visits while you are hospitalized are paid at 90% of R&C after the deductible requirement has been satisfied.

Effective January 1, 1991, where it is economically feasible, and where sufficient physicians elect to participate, MAP will implement Preferred Provider Organizations (PPOs) for physicians with benefits for non-emergency covered charges paid as follows.

- If you live in a PPO area (see the definition of "PPO area" on page 9):
  - — PPO physician services will be paid at 90% of covered charges less a $5 copayment, no deductible required.
  - — Non-PPO physician services will be paid at 80% of PA, after the deductible has been met.
- If you do not live in a PPO area, PPO and non-PPO physician services will be paid at 90% of R&C, after the deductible has been met.

Covered charges include one hospital visit a day by your primary physician. Inpatient consultations by physicians other than your primary physician are limited to one consultation for each specialty, per admission. Benefits for emergency physician care are explained on page 58.

Inpatient physician charges which are not billed by the facility for services by staff physicians in connection with substance abuse rehabilitation are excluded.

Office visits and services for routine health check-ups or examinations are not covered under MAP (unless for a diagnosed condition or stated specifically as being covered by MAP).

Chiropractic Charges

MAP pays the same benefits as explained on page 40 — up to a $100 benefit for the first visit covered under MAP on or after January 1, 1990, and up to a $50 benefit for subsequent visits.

Covered charges are limited to 2 visits each 7 consecutive calendar days and 20 visits each calendar year. Charges above these limits on visits do not apply to the deductible or out-of-pocket limit.

Anesthesia Administration

Benefits for the administration of anesthesia by a physician other than your surgeon or his or her assistant are paid the same as other covered physician fees (page 40).

INPATIENT SURGEON'S CHARGES

These charges, which include all post-operative services, are paid at 90% of R&C after the deductible requirement has been satisfied. For coverage information on maternity-related expenses, refer to page 59.

When the surgery requires the services of an assistant surgeon, his or her fee is also covered at 90% of R&C after the deductible has been met.

Effective January 1, 1991, inpatient surgeon's charges will be paid at the same percentages as physician charges for office and hospital visits on or after January 1, 1991 (page 40).

Surgical Benefits For Multiple Procedures Performed During The Same Operative Session

When more than one surgical procedure is performed during the same operative session, MAP does not cover the full reasonable and customary charges for each procedure. Covered expenses are determined as follows:

- Multiple surgical procedures during the same operative session performed through the same incision or in the same operative fields are covered up to the surgeon's reasonable and customary charge for the most expensive procedure.
- Multiple surgical procedures performed during the same operative session through separate incisions and in separate operative fields are covered up to the surgeon's reasonable and customary charge for the total procedure but not more than the reasonable and customary charge for the more expensive procedure and 50% of the reasonable and customary charge for the less expensive procedure(s).
- Bilateral procedures (for example, removing cataracts from both eyes) performed during the same operative session in separate operative fields are covered up to the surgeon's reasonable and customary charge for the total procedure up to 150% of the reasonable and customary charge for the unilateral procedure.

Effective January 1, 1991, MAP will increase coverage for the following multiple surgical procedures when performed during the same operative session:

- Cesarean-Section with Tubal Ligation;
- Vaginal Delivery with Tubal Ligation;
- Hysterectomy with Appendectomy; and
- Laparotomy with Dilation and Curettage.

MAP benefits for these multiple surgical procedures when provided by a PPO physician will be 90% of covered charges less a $5 copayment.

MAP coverage for non-PPO physician charges for the procedures listed on the prior page will be paid on a scheduled basis for each state. Therefore, benefits will be approximately 50% of R&C payments for secondary procedures previously not covered, and approximately 75% of R&C for the secondary procedures previously paid at 50% of R&C. Non-PPO physician charges will be subject to the MAP deductible. Amounts above the scheduled payments will not be considered covered charges. Covered charges will be determined as follows:

- Multiple surgical procedures during the same operative session performed through the same incision or in the same operative fields are covered up to the surgeon's reasonable and customary charge for the most expensive procedure and at approximately 50% of reasonable and customary charges for the other procedures.
- Multiple surgical procedures performed during the same operative session through separate incisions and in separate operative fields are covered up to the surgeon's reasonable and customary charge for the total procedure but not more than the reasonable and customary charge for the more expensive procedure and approximately 75% of the reasonable and customary charge for the less expensive procedure(s).

OUTPATIENT SURGEON'S CHARGES

Prior to January 1, 1991, the surgeon's fee for outpatient surgery is paid at 100% of R&C. The deductible is required for all outpatient surgeries except those on the Mandatory Outpatient Surgical Procedures List on page 44.

Effective January 1, 1991, benefits for all outpatient surgeon's charges, including charges for procedures listed on the Mandatory Outpatient Surgical Procedures List (below), will be as follows.

- If you live in a PPO area:
  - — PPO physician services will be paid at 90% of covered charges less a $5 copayment, no deductible required.
  - — Non-PPO physician services will be paid at 80% of PA, after the deductible has been met.
- If you do not live in a PPO area, PPO and non-PPO physician services will be paid at 90% of R&C, after the deductible has been met.

Mandatory Outpatient Surgical Procedures List

Procedure	Description
Dilation and Curettage*	Dilation and scraping of uterus
Excision of lesions of skin subcutaneous and soft tissue (malignant/benign)	Removal of cysts, tumors, lipomas, etc.
Eye muscle operations	Surgery to correct muscle imbalance
Hammer toe repair	Surgery to correct congenital deformity of toes
Hemorrhoidectomy*	Removal of hemorrhoids
Herniorrhaphy*	Hernia repair
Mastoidectomy	Removal of part of mastoid process
Neuroplasty	Surgery on nerves/nerve tissue
Submucous resection	Partial excision of nasal septum
Tendon (sheath) release/repair	Incision or repair of tendons
Varicose vein ligation*	Surgery on enlarged veins

* Procedures included on both this list and the Second Surgical Opinion List.

For maximum MAP benefits, QCP pre-certification is not required for any procedure listed on page 44 when it is performed on an outpatient basis unless it is also on the Second Surgical Opinion List, page 47.

MANDATORY OUTPATIENT SURGICAL PROCEDURES PERFORMED ON AN INPATIENT BASIS

MAP will cover inpatient expenses for a procedure listed on page 44 only when it is medically necessary to have the procedure performed on an inpatient basis. If a mandatory outpatient procedure is performed on an inpatient basis without QCP pre-certification, MAP will only cover the expenses that would have been paid if the procedure had been performed on an outpatient basis.

Also, inpatient expenses will be covered under MAP when QCP confirms that there is no outpatient facility within 25 aerial miles of your home.

SURGICAL OPINIONS

When you or a covered dependent need surgery and that procedure is on the Mandatory Second Surgical Opinion List (page 47), contact QCP. QCP will review your medical circumstances and determine if a second surgical opinion will be required or if it can be waived as a condition to receiving maximum MAP benefits.

If you do not obtain a second opinion when QCP requires it and you proceed with surgery, the QCP Penalty will be applied.

When a required second opinion does not agree with your physician's recommended treatment, the following options are available to you:

- Your physician, you or a family member may contact QCP to discuss alternatives to surgery.

- You may contact QCP to obtain a third opinion from another physician by following the same procedure as for a second opinion and the same benefit levels will apply.
- You may choose not to obtain a third opinion and proceed with the surgery but, either . . .
  - — Your MAP payment will be subject to the QCP Penalty, or
  - — The expenses will not be covered, or paid, if Blue Cross and Blue Shield determines that the surgery was not medically necessary.

When a required third opinion does not confirm the need for surgery, your options are as follows:

- Contact QCP to discuss your alternatives.
- You may have the surgery but, either . . .
  - — Your MAP payment will be subject to the QCP Penalty, or
  - — The expenses will not be covered, or paid, if Blue Cross and Blue Shield determines that the surgery was not medically necessary.

If you choose to proceed with surgery on an inpatient basis, when there is no confirming opinion and QCP does not certify the confinement, more than one QCP Penalty will be applied.

Keep in mind, it is always up to you and your doctor whether or not you have the surgery.

SURGICAL OPINION PAYMENTS

MAP pays for required second or third surgical opinions as follows:

- If a QCP-listed physician is used, the opinion is paid in full.
- If a QCP-approved but not listed physician is used, the opinion is paid at 100% of R&C.
- If the opinion is obtained without QCP authorization or from a physician who is not approved by QCP, the cost of the opinion is not a covered expense — no payment will be made by the Plan.

In addition, if the physician rendering the second or third opinion performs the surgery, the charge for the physician's service (surgery), including the cost of the opinion, will not be a covered expense.

PROCEDURES REQUIRING A CONFIRMING SECOND OPINION

The procedures listed below require QCP contact and, unless waived by QCP, a confirming second surgical opinion for maximum MAP benefits.

Mandatory Second Surgical Opinion List

Procedure	Description
Arthroplasty	Reconstruction of hip joint
Cardiac Catheterization	Diagnosis of heart disorders and anomalies through insertion of plastic tube in heart
Cardiac Pacemaker	Implanting artificial regulator for heart muscle
Cataract Removal	Removal of cataracts in eyes
Chemonucleoysis	Treatment of herniated disc
Cholecystectomy	Removal of gallbladder
Coronary By-Pass	Surgery of coronary artery
Dilation and Curettage	Dilation and scraping of uterus

Procedure	Description
Hallux Valgus Procedures	Surgery of big toe to correct deformity, including bunionectomy
Hemorrhoidectomy	Removal of hemorrhoids
Herniorrhaphy	Surgical repair of hernia
Hiatal Herniorrhaphy	Surgical repair of hiatal hernia
Hysterectomy	Removal of uterus
Intestinal Operations	Elective only, including the stomach
Knee Operations	Elective knee operations only
Laminectomy	Removal of vertebral arch
Mastectomy	Removal of breast
Meniscectomy	Removal of torn cartilage in the knee
Ostectomy or Osteotomy	Bone surgery of the foot
Percutaneous Transluminal Angioplasty	Removal of arterial blockage without by-pass
Pneumonectomy	Removal of all or part of lung
Prostatectomy	Removal of all or part of prostate gland
Rhinoplasty	Surgical reconstruction of the nose, including submucous resection
Spinal Fusion	Fusion of spinal vertebrae
Tenosynovectomy	Surgery on tendon sheath (wrists only)
Tonsillectomy or Adenoidectomy	Removal of tonsils or adenoids
Varicose Veins of Legs	Removal of varicose veins

OBTAINING A SECOND/THIRD OPINION

If QCP requires you to obtain a second or third surgical opinion, QCP will provide you with the names of board-certified or board-eligible physicians (three or more whenever possible) from which you may select one to provide the surgical opinion. "Board-certified" means that the physician has taken and successfully completed the necessary examinations for certification in his or her area of specialty. "Board-eligible" means that the physician meets board requirements but has not yet taken the examinations required for certification.

25-Mile Waiver

If there is no board-certified physician within 25 aerial miles of your home, the second surgical opinion may be waived by QCP. However, QCP may recommend that you obtain a second surgical opinion from a board-eligible physician.

Paid Time-Off

When QCP requires and pre-certifies a second or third surgical opinion, the Company will allow you paid time-off to see the physician for that opinion. Paid time-off applies only when the required second or third opinion is for your illness or injury — not your dependent's.

WHEN QCP IS NOT CONTACTED

If QCP is not contacted, or a confirming second or third surgical opinion is not obtained when required, the QCP Penalty will apply. However, if it is determined by Blue Cross and Blue Shield that the surgery was not medically necessary, the expenses will not be covered or paid by MAP. **Remember, the decision to have surgery is up to you and your doctor.**

SECTION 9. MENTAL AND NERVOUS CARE BENEFITS

For purposes of MAP, the term "mental and nervous" includes alcoholism and drug addiction which are referred to in this booklet as substance abuse.

BENEFIT LIMITATIONS

MAP will pay up to an individual lifetime maximum benefit of $150,000 for combined inpatient, partial hospitalization and outpatient mental and nervous care covered expenses. Once a participant reaches this limit, any additional mental and nervous expenses will not be covered and will not count toward the participant's deductible or out-of-pocket limit.

MAP pays for two substance abuse rehabilitation benefits per lifetime; one inpatient benefit and one partial hospitalization benefit. The second benefit must start at least 180 days after the first one ended to be considered separate from the first.

In addition, specific benefits have special limits as described in this Section.

Special Rules For PPO And Non-PPO Hospital Benefits

For all mental and nervous confinements, including confinements for substance abuse, the lower benefit level will be paid for non-PPO hospital charges incurred in a PPO area — regardless of where the participant lives. This means that if you live outside the PPO area, you must use a PPO facility to obtain maximum MAP benefits if you receive treatment within a PPO area.

Benefits for Medicare eligibles, whether or not a PPO hospital is used, are the same as the PPO hospital benefits.

However, Medicare eligibles are encouraged to use a PPO hospital whenever possible.

The amount you pay does not apply to the out-of-pocket limit. In addition, once the out-of-pocket limit is reached, benefits will not increase to 100%.

INPATIENT BENEFITS

All inpatient confinements for mental and nervous treatments (including those for Medicare eligibles) must be pre-certified by QCP as a condition for receiving MAP benefits. This means that if QCP does not certify the admission, the inpatient expenses are not covered, not reimbursed and do not apply toward the deductible or the out-of-pocket limit.

As for other benefits, mental and nervous confinements will be reviewed during the hospitalization to determine the portion of care that is medically necessary treatment versus that which is maintenance or custodial and not covered under MAP.

Hospital Benefits: Other Than For Substance Abuse Care

Once QCP has certified the confinement, and once the deductible has been met, MAP pays inpatient hospital benefits for mental and nervous conditions as follows:

DAYS IN THE HOSPITAL	PPO HOSPITAL OR NO PPO HOSPITAL AVAILABLE IN AREA	NON-PPO HOSPITAL WITHIN ANY PPO AREA
Less than 30	100% of covered charges	90% of payment allowance
30 - 59	95% of covered charges	85% of payment allowance
60 - 89	90% of covered charges	80% of payment allowance
90 or more	85% of covered charges	75% of payment allowance

Physician benefits are the same as for other inpatient illnesses (Section 8).

Hospital Benefits: Substance Abuse Care
Once certified by QCP, benefits are paid as follows after the deductible has been met:

- 100% of covered inpatient hospital charges from a PPO hospital;
- 100% of covered inpatient hospital charges from a non-PPO hospital if the participant does not live in a PPO area and the non-PPO hospital is not located in a PPO area; and
- 90% of the PPO area payment allowance for covered inpatient hospital charges from a non-PPO hospital located inside a PPO area.

Covered hospital charges for substance abuse care have the limitations noted below.

Inpatient Detoxification Benefits
MAP covers hospital and physician charges for up to 30 days for each detoxification benefit. No more than 2 detoxifications during a 5-year period are covered. The second benefit must start at least 180 days after the first one ended to be considered separate from the first.

Inpatient Substance Abuse Rehabilitation Benefits
MAP covers hospital charges for one inpatient rehabilitation program per lifetime for up to 30 days for active employees, retired employees, surviving spouses and Class I dependents. Rehabilitation benefits already used under MEP count toward this limit. Any fees (including physician fees) separately billed from the inpatient facility program charge are not covered under MAP.

OUTPATIENT MENTAL AND NERVOUS BENEFITS
Once the deductible is met, MAP pays physician's fees at 90% of R&C up to $50. In addition, MAP limits this benefit to 2 visits during any 7 consecutive calendar days and 52 visits each calendar year.

PARTIAL HOSPITALIZATION/SUBSTANCE ABUSE REHABILITATION PROGRAM BENEFITS (ALTERNATE BENEFIT)
A partial hospitalization is when a patient is admitted to the hospital under an approved treatment or rehabilitation program and the daily stay is for less than 24 hours.

Expenses from an approved day or evening rehabilitation program are paid at 100% of R&C, after the deductible, limited to one partial hospitalization benefit per lifetime.

An approved partial hospitalization/substance abuse rehabilitation program is a program that is:

- Approved by the Joint Commission on Accreditation of Health Care Organizations;
- Usually four to six weeks in duration — either day or evening;
- Specifically for the treatment of addictions; and
- Specifically tailored to address the problem of substance abuse.

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Remember, all mental and nervous treatment decisions are up to you and your doctor.

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SECTION 10. PRESCRIPTION DRUG BENEFITS

Under MAP, you have three different options covering prescription drug benefits. You can purchase your prescriptions from:

1. The Mail Order Prescription Drug Program;
2. Preferred Provider Organization (PPO) pharmacies; or
3. Any pharmacy and submit a claim for general MAP benefits.

Regardless of which option you choose, MAP covers the R&C cost of generic prescription drugs.

If a generic substitute is not available or if your physician will not allow a generic substitute, MAP will cover the R&C cost of the namebrand prescription drug.

Drugs that may be purchased over-the-counter (without a prescription) are not covered by MAP — even if your physician "prescribes" them — except for prenatal vitamins as explained on page 60.

Copayments for the Mail Order Prescription Drug Program and PPO pharmacies do not apply to the deductible or out-of-pocket limit. In addition, those copayments will always be required — even if the out-of-pocket limit has been reached.

THE MAIL ORDER PRESCRIPTION DRUG PROGRAM

If you take prescribed drugs on a regular or maintenance basis, you may order those prescription drugs through this program. In addition, your covered dependents may use this program if:

- MAP is their primary plan, or
- Coverage is provided by Medicare.

Rules for determining when MAP is the primary plan are explained in Section 12.

How The Program Works

The Mail Order Prescription Drug Program is administered by Baxter Healthcare Corporation. No deductible is required. Your copayment for each prescription is not eligible for reimbursement from MAP.

For each covered prescription drug ordered, you will be sent the quantity your doctor prescribed — up to a 90-day supply.

Baxter Healthcare Corporation's Prescription Service Division will fill each covered prescription drug with a generic drug when one is available and the substitution is permissible by law unless you or your doctor require the use of a namebrand drug.

You should receive your prescription drug via United Parcel Service (UPS) or First Class U.S. Mail within 10 to 14 days after Baxter receives your Prescription Order Form. However, if the prescription is for a namebrand drug and a generic drug is available and allowed by your physician, you must pay the difference between the namebrand drug cost and the generic drug cost plus the $7 copayment. Baxter will notify you, by letter, of the additional payment and the credit card method of paying before filling the prescription. Therefore, it will take longer to process your order.

Your Cost

Your cost is either a $7 copayment or a $4 copayment and a $3 coupon for each covered prescription drug.

When a generic drug is sent to you, a $3 coupon will be included along with your prescription order. This $3 coupon

can be used as a credit against the required $7 copayment for your next prescription order or refill for either a generic or namebrand drug. Only one coupon may be used for each drug.

In addition, you pay any difference in cost plus a $7 copayment for ordering a namebrand drug when not prescribed by your physician and a generic substitution is available.

BellSouth pays the remainder of the covered drug cost plus all handling and administrative costs of this program.

How To Order A Prescription Drug

To order a prescription drug, all you need to do is mail your original prescription(s), completed Prescription Order Form, Patient Profile Form and appropriate payment for each prescription in the pre-addressed envelope.

Patient Profile/Prescription Order Forms are available by calling Baxter toll-free at **1-800-824-6349** between 8:30 a.m. and 8:00 p.m., Eastern Time (Monday through Friday).

PREFERRED PROVIDER ORGANIZATION PHARMACIES

A PPO network of pharmacies is being developed to provide prescription drugs to MAP participants. You will be notified when the PPO pharmacy network is established in your area. Then, you may call Blue Cross and Blue Shield for the names of the participating pharmacies located near you.

PPO Pharmacy Benefits

You have the option of purchasing covered prescription drugs from a PPO pharmacy for a copayment of $10 for each prescription for up to a 30-day supply. No deductible

or claim form is required. When the prescription drug cost is less than $10, the copayment will be the cost of the drug.

GENERAL PRESCRIPTION DRUG BENEFITS

MAP pays 90% of R&C, once the deductible has been met, for covered drugs from any pharmacy. To receive MAP benefits, you must submit a completed claim for the drug(s) to Blue Cross and Blue Shield. Beginning January 1, 1990, a new Drug Claim Form will be used that requires the National Drug Code number before a claim can be processed so that all drug usage and cost data may be retained by Blue Cross and Blue Shield.

SECTION 11. ADDITIONAL PLAN PROVISIONS

ACCIDENTAL INJURY AND SUDDEN/SERIOUS ILLNESS

If you or a covered dependent have an accidental injury or a sudden or serious illness, there is a special MAP provision to cover the related facility charges if treated within 72 hours.

The benefits paid for covered charges from an ambulatory surgical facility or a hospital outpatient or emergency room department are based on the date expenses are incurred as explained below.

Prior to January 1, 1991, emergency covered facility charges will be paid in full with no deductible required.

On or after January 1, 1991, emergency covered facility charges for:

- SPECIFIED EMERGENCY CONDITIONS such as those resulting in the patient being hospitalized, bone fractures, abrasions, lacerations, poisoning and rape will be paid in full with no deductible required.
- NON-SPECIFIED EMERGENCY CONDITIONS will be paid as follows . . .
  - — PPO facility charges will be paid in full after a $25 copayment.
  - — Non-PPO facility charges will be paid in full after a $50 copayment.

Copayments for non-specified emergency conditions do not apply to the deductible or out-of-pocket limit.

MAP pays the physician's or surgeon's fees at 90% of R&C, no deductible required.

If the injury or illness requires hospitalization and the admission is approved by QCP, MAP pays benefits as described in Sections 7 through 8.

MATERNITY CARE

Prior to January 1, 1991, MAP pays 100% of R&C for pre and postnatal care by the obstetrician with no deductible required. Coverage for nurse midwives is explained under Alternate Benefits on page 31.

Effective January 1, 1991, the same level of benefits as detailed immediately above will apply with the use of a PPO physician or if you live outside of a PPO area. If you live in a PPO area and you do not use a PPO physician, MAP will pay 80% of the payment allowance after the deductible has been satisfied.

Inpatient hospital expenses for maternity are covered the same as any other illness or injury (Section 7). Remember, QCP must be contacted if your admission is expected to last longer than 48 hours.

Well Baby Pediatric Examination

Prior to January 1, 1991, MAP pays 90% of R&C for one "well baby" pediatric examination of a newborn child during the mother's confinement with no deductible required. Routine nursery charges are covered under the Hospital Care Benefits (Section 7) provisions of MAP with no deductible required.

Effective January 1, 1991, the same level of benefits as detailed immediately above will apply with the use of a PPO physician or if you live outside of a PPO area. If you live in a PPO area and you do not use a PPO physician, MAP will pay 80% of the payment allowance after the deductible has been satisfied.

WELL CHILD CARE

MAP will pay 90% of R&C charges less a $5 copayment for routine exams and immunizations to age 6 and annual screenings for ages 6 to 12. MAP covers up to $250 for each child (pre and postbirth) and $400 for each family during any calendar year. Amounts not paid due to the annual limit having been met and the $5 copayment do not apply to the deductible or out-of-pocket limit.

In addition, prenatal vitamins are covered by this provision under MAP's various drug programs (Section 10).

No deductible is required for physician services.

ADOPTION BENEFITS

Following the adoption and enrollment of an eligible dependent, MAP provides regular Plan benefits for up to $1,000 of covered charges incurred between the time the dependent was placed in your home and the court's filing of the adoption papers at which point the child becomes a Class I dependent.

MAMMOGRAPHY

Mammograms due to a covered diagnosed condition are paid at 90% of R&C after the deductible has been met without any restrictions on age.

Effective January 1, 1991, MAP will pay 100% of R&C charges, with no deductible required, for one base line screening between the ages of 40 and 49 and one annual screening at age 50 and older. (Coverage for diagnosed conditions will continue as detailed above.)

PAP SMEARS

The laboratory fees for routine pap smears are paid at 100% of R&C with no deductible required.

CHEMOTHERAPY AND RADIATION THERAPY

MAP pays 100% of R&C for the cost of chemotherapy and radiation therapy (for the agent and administration of the agent but not for hospital charges) with no deductible required.

HUMAN ORGAN TRANSPLANTS

MAP coverage for human organ transplants is only covered under the circumstances described in this section and is limited to the following procedures:

- Bone marrow;
- Cornea;
- Heart; and
- Kidney.

Bone marrow, heart and kidney transplants must meet the following criteria before being covered under MAP:

- The patient has no other terminal disease requiring treatment that would not be affected by the transplant;
- The patient satisfies the selection criteria of the facility to which he or she has been referred; and
- The procedure must be performed in approved facilities which have demonstrated a high degree of success. The names of these facilities are available from QCP.

In addition, bone marrow and heart transplants must also meet the following requirements before they will be covered under MAP:

- The patient must be faced with a life-threatening illness and all conventional therapies have been performed but have not cured or lessened the medical situation, and
- The transplant has a reasonable probability of success which will lead to a higher quality of life.

Autologous bone marrow transplants are covered under MAP only for the following conditions:

- Advanced Hodgkins Disease in individuals who have failed conventional treatment and have no compatible donor;
- Acute leukemia in remission in individuals who have a high probability of relapse and no compatible donor; and
- Specific resistant Non-Hodgkins lymphomas.

ANESTHESIA ADMINISTRATION

Benefits for the physician's fee to administer anesthesia are paid the same as other physician's fees (page 40).

ADDITIONAL MAP BENEFITS

In addition to the benefits already explained in this booklet, MAP also covers other supplies and services. MAP pays 90% of R&C, once the deductible has been met, for the following:

- Anesthesia when in connection with surgical procedures covered by MAP;
- Physical therapy/physiotherapy if prescribed by a physician and performed by a qualified physiotherapist;
- Blood (if not donated or otherwise replaced);
- Initial placement of artificial limbs and eyes (but not their replacements);
- Prescribed durable medical equipment — e.g., wheelchairs;
- Local ambulance service to the nearest hospital where treatment is first given (benefits increase to 100% for a transfer to a PPO hospital when it is pre-certified by QCP); and

- Private duty nursing, if pre-certified by QCP; however, the following criteria apply . . .
  - — Expenses incurred for the professional services of a registered graduate nurse (RN) or a licensed practical nurse (LPN) — other than a nurse who resides in the covered individual's home or who is a member of such individual's immediate family — may be covered, and
  - — Payment will be made for only that portion of the nurse's services performed that require the special knowledge and skill of a trained professional nurse, and then only upon receipt of a physician's written documentation of such need and a listing of the special care services to be provided.

Nursing care is not covered for custodial/routine patient care or care that is provided by a non-professional individual.

WHAT THE PLAN DOES NOT COVER

Although MAP covers a broad range of services and supplies, there are some items — as in all plans of this type — that are excluded and are not covered. These include but are not limited to:

- Saturday and Sunday hospital room and board charges for non-emergency Friday and Saturday admissions except as explained on page 36;
- Expenses due to a pre-existing condition, page 25;
- Charges for any services received before coverage under MAP began;
- Expenses due to an occupational illness or injury which are covered by Workers' Compensation;
- Routine health check-ups or examinations unless specifically stated under MAP's provisions;

- Diagnostic tests (unless specifically stated under MAP's provisions) which do not reveal either an illness or injury unless you submit satisfactory proof that you had specific symptoms of a condition requiring medical attention;
- Charges paid or payable under the laws of any country — or for which you have no legal obligation to pay;
- Namebrand prescription drug charges in excess of the cost for generic drug substitutes when a generic drug is available and allowed by the prescribing physician;
- Over-the-counter drugs, even if prescribed (except for prenatal vitamins, page 60);
- Charges in excess of those considered reasonable and customary;
- Charges in excess of payment allowance limits;
- Hospitalization for dental care unless required because of an accident or to safeguard your health, page 37;
- Charges for any dental work or treatment except to the extent specifically provided under MAP's provisions, page 37;
- Outpatient facility charges from other than an ambulatory surgical facility or an outpatient department of a hospital (emergency room expenses are only covered as explained under the "Accidental Injury And Sudden/Serious Illness" provision, page 58);
- Charges for any surgery or medical treatment, including drugs, which are considered experimental, investigative or exploratory;
- Charges for in-hospital personal services — e.g., radio and television rentals, guest meals, barber, etc.;

- Mail Order Prescription Drug Program copayments (Section 10);
- PPO pharmacy copayments (Section 10);
- Physician copayments, such as the $5 copayment for the well child care benefits, page 60, and the PPO physician copayments;
- Amounts (other than any covered expenses applied to the deductible) in excess of payments for mental and nervous care;
- Charges for eyeglasses or hearing aids and related examinations or prescriptions for them, except initially because of surgery;
- Charges for care in a nursing or convalescent home (unless approved by QCP);
- Charges for custodial care or rest cures;
- Services or expenses related to the non-surgical management of Temporomandibular Joint Dysfunction (TMJ);
- Charges above MAP coverage limits;
- Cosmetic surgery or treatment unless required because of an accident which occurred after coverage under MEP or MAP began or to correct a birth defect if such correction results in an improvement of bodily function;
- Expenses for an illness or injury caused by an act of war — declared or undeclared; and
- Charges from a certified registered nurse anesthetist or social worker.

MAP is intended to reimburse you for medically necessary expenses incurred for the care and treatment of a non-occupational illness or injury. Therefore, any charges for

care, treatment, services or supplies that are not determined to be medically necessary for the treatment of a non-occupational illness or injury or which are provided solely for your convenience are considered exclusions and will not be covered by MAP.

* * * * * *

Remember, you and your doctor are responsible for making all decisions regarding your medical treatment.

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SECTION 12. COORDINATION OF BENEFITS

The growing number of medical plans and the increasing number of two-income families mean that many people are either covered or have the opportunity to be covered under more than one group plan. Under these circumstances, it is not intended that MAP provide duplicate benefits. For this reason, MAP contains a Coordination of Benefits (COB) provision which is designed to ensure benefits up to your MAP benefit levels on each claim while preventing duplication of payment.

COB applies when an employee or dependent is covered — or eligible, in certain circumstances, for coverage — by more than one group plan or by Medicare as explained in Section 13. Under MAP, a group plan is a medical plan offered by an employer (businesses, partnerships, individual owners, etc.) to its employees at no cost or at a cost subsidized by the employer. For example, multiple-choice, flexible benefit plans, ERISA-type plans, federal/state/local government plans and certain church plans are considered group plans.

If an employer simply offers a plan for the convenience of its employees by collecting the premiums, but does not contribute to its cost, the plan is not considered a group plan.

The COB provision does not apply to any individual or personal policies of insurance.

WHEN COORDINATION OF BENEFITS DOES NOT APPLY

When a person is covered under a Health Maintenance Organization (HMO), BellSouth does not coordinate benefits. In addition, there is no COB between BellSouth Participating Companies. (For a list of Participating Companies, see the inside front cover of this booklet.)

PRIMARY/SECONDARY COVERAGES

The plan that considers expenses first is the **primary** plan. The plan that waits for the primary plan to consider expenses is the **secondary** plan.

When MAP is the secondary plan, combined benefits from both the primary and secondary plans may not total more than the amount MAP would have paid alone. In other words, MAP will coordinate benefits up to MAP benefit levels. Also, MAP will only pay benefits for expenses covered by MAP.

MAP coordinates with other group health plans according to the following rules.

- A plan which has no rules for coordinating benefits with other plans is primary.
- A plan which has a secondary-only rule for its employees when another coverage is available will be primary.
- A plan which covers a person as an employee or in some capacity other than as a dependent is primary.
- For children and other dependents, the plan of the parent or sponsor whose birthday comes first in the year will be primary. This is referred to as the "birthday rule". If a plan has not adopted the "birthday rule", then that plan's rules will determine which plan is primary (generally the male's plan).

  However, if your spouse works and declines dependent coverage because contributions for dependent coverage are required, MAP will provide full Plan benefits for your dependent children and not just secondary-only coverage.
- For children whose parents are divorced or separated, the following rules apply:
  - — If there is a court order establishing which parent has financial responsibility for the child's health care expenses, that parent's plan will be primary.
  - — If there is no such court order and the parent with custody has not remarried, that parent's plan is primary.
  - — If there is no court order and the parent with custody has remarried, plans covering the child will pay benefits in the following order . . .
    1. The plan of the parent with custody,
    2. The plan of the step-parent with custody, and
    3. The plan of the parent without custody.
- If none of the rules listed above establish an order of payment, the plan which has covered the person the longest will be primary.

An Example

Assume:

- Your spouse is an active employee of AB & Company (ABC) and is covered by ABC's plan; therefore, ABC's plan is primary.
- Your spouse has surgery on March 1, 1990; surgeon's fees of $1,000 are within R&C limits and covered under both plans.
- Deductibles under both plans have been met.
- MAP's benefit level is 90%.
- ABC's plan benefit level is 80%; therefore, as the primary plan, ABC's plan considers the expense first and pays $800 (80% x $1,000).

Since MAP is the secondary plan, MAP pays the difference between MAP's benefit and ABC's plan payment.

MAP benefit (90% x $1,000)	$900
ABC pays (80% x $1,000)	-800
MAP pays	$100

The $800 subtracted from your spouse's MAP benefit and paid by ABC's plan does not apply toward MAP's deductible or out-of-pocket limit.

COB RULES: WHEN YOUR SPOUSE IS EMPLOYED

If Your Spouse Declines His/Her Employer's Group Plan

COB rules **affect** you if your spouse works and **declines** his or her employer's group plan coverage when that employer contributes:

- **All or any part** of the cost of the coverage for its employees when your spouse works 30 or more hours a week;
- **The full cost** of coverage for its employees when your spouse works less than 30 hours a week; or
- **The full cost of dependent** coverage if that coverage would be primary according to COB rules.

MAP will pay normal benefits minus the benefits that would have been paid by your spouse's employer's plan had your spouse elected coverage and assuming that your spouse had met that plan's deductible. In other words, MAP benefits are reduced by benefits that were **available** even though they were not elected.

However, if you retired prior to January 1, 1988, and your spouse declines his or her current or former employer's coverage because contributions from your spouse are required, MAP will provide full Plan benefits and not secondary-only coverage.

An Example: Spouse's Expenses

Assume:

- You are an active employee.
- Your spouse is an active employee of AB & Company (ABC) and works more than 30 hours each week.
- ABC pays a portion of the cost for medical coverage but your spouse has declined coverage; however, ABC's plan is considered primary for your spouse's expenses.

- Your spouse has surgery on March 1, 1990; surgeon's fees of $1,000 are within R&C limits and covered under both plans.
- Your MAP deductible has been met.
- MAP's benefit level is 90%.
- ABC's plan benefit level is 80%; therefore, ABC's plan would have paid $800 (80% x $1,000).

Since your spouse's employer sponsors a medical plan and makes a contribution to that plan's cost, the COB rules will be applied and ABC's plan benefits will be taken into account when determining MAP's benefit payment.

If MAP were the primary plan, MAP would have paid $900 on this claim; but, since it's considered the secondary plan, MAP instead pays the difference between its normal payment and ABC's plan benefit determined this way:

MAP benefit (90% x $1,000)	$900
ABC benefit (80% x $1,000)	-800
MAP pays	$100

MAP pays $100 even though the ABC plan did not actually pay the $800. And, the $800 subtracted from your spouse's MAP benefit and paid by your spouse does not apply toward MAP's deductible or out-of-pocket limit.

If your spouse had not declined coverage, the benefit from MAP would have been $100.

An Example: A Dependent Child's Expenses

Keeping the same assumptions used in the previous example, suppose the $1,000 medical claim is for surgery on your child and it's submitted to MAP.

Also assume that your spouse's plan would be primary and that although dependent coverage at ABC is provided at **no cost** to your spouse, your spouse **declined it**. However, according to MAP's Coordination of Benefits rules, ABC's plan benefits would be taken into account when determining MAP's benefit.

If MAP were the primary plan, MAP would have paid $900 on this claim; but, since it's the secondary plan, MAP instead pays the difference between its normal payment and ABC's plan benefit as follows:

MAP benefit (90% x $1,000)	$900
ABC benefit (80% x $1,000)	-800
MAP pays	$100

MAP pays $100 even though ABC's plan did not actually pay the $800. And, as in the prior example, the $800 paid by you and/or your spouse does not count toward MAP's deductible or out-of-pocket limit.

If your spouse had not declined dependent coverage in this example, the benefit from MAP would have been $100.

If Your Spouse Is Self-Employed

Special COB rules apply if your spouse:

- Is eligible for group medical coverage through a professional association and declines that coverage, or
- Has employees and provides them with group medical coverage.

MAP will pay normal benefits minus the benefits that would have been paid by your spouse's plan had your spouse elected coverage and assuming that your spouse had met that plan's deductible. In other words, MAP benefits are reduced by benefits that were **available** even though they were not elected.

COB Rules For "Multiple-Choice" Medical Benefits

If your spouse works 30 or more hours a week and his or her employer/former employer offers a cafeteria-style, flexible benefits program or any other type of multiple-choice benefit group plan (regardless of the cost to your spouse), and your spouse either elects or declines medical coverage, BellSouth will coordinate benefits as follows.

- If your spouse declines coverage or elects an option that costs less than the mid-priced option, MAP will coordinate benefits as if your spouse elected his or her employer's mid-priced option. In other words, the mid-priced option will be used even if your spouse chooses a less expensive option.
- If your spouse elects the mid-priced option or a more expensive option, the option elected will be used to coordinate benefits with MAP.

If the mid-priced option cannot be determined, the most popular option will be used instead of the mid-priced option. The most popular option is determined by the elections made by participants in the group eligible for the options at your spouse's employer/former employer.

Once it has been determined which medical option to apply, benefits will be coordinated according to MAP's COB provisions.

An Example: Flexible Benefits

Assume:

- Your spouse is an active employee of AB & Company (ABC) and works more than 30 hours each week; therefore, ABC's plan is primary for your spouse.
- Your spouse has surgery on March 1, 1990; surgeon's fees of $1,000 are within R&C limits and covered under both plans.
- Your MAP deductible has been met.
- MAP's benefit level is 90%.
- ABC offers your spouse three different medical options. Each option covers the same expenses but at different rates: Option A pays 70% of the covered expenses; Option B pays 80%; Option C pays 90%. However, your spouse declines coverage under any option.
- The mid-priced option is Option B which pays 80% of covered expenses; therefore, ABC's plan would pay $800 (80% of $1,000).

According to COB rules, MAP coverage is secondary. Therefore, COB rules will be applied and Option B benefits (ABC's mid-priced option) will be taken into account when determining MAP's benefit payment as follows:

MAP benefit (90% x $1,000)	$900
ABC Option B benefit (80% x $1,000)	-800
MAP pays	$100

MAP pays $100 even though ABC's plan did not actually pay the $800. And, the $800 paid by your spouse does not apply toward MAP's deductible or out-of-pocket limit.

If your spouse had not declined coverage but had elected Option A or Option B, the benefit from MAP would still have been $100 because MAP coordinates benefits with the mid-priced option; in this case, Option B.

If a better or higher-priced option is elected by your spouse, COB will be applied based on the benefits provided by that option. For example, if Option C had been elected, no MAP benefits would have been paid because Option C's benefit level of 90% is the same as the MAP benefit level. And according to COB rules, MAP coordinates benefits only up to MAP benefit levels.

SECTION 13. WHEN YOU ARE ELIGIBLE FOR MEDICARE

There are two parts to Medicare:

- Part A — which provides benefits for hospital care, and
- Part B — which provides benefits toward physician's fees and certain other covered medical expenses.

Based on current federal law, you and your dependents may become eligible for both parts of Medicare upon reaching age 65 — or before age 65 if disabled and 24 months of disability payments have been received from Social Security. Medicare is also available at any age if the participant has End-Stage Renal Disease.

You should contact your local Social Security office for information on how to enroll in Medicare. Part A is paid in full by Medicare. For Part B, the government charges a monthly premium. However, the Company currently reimburses the Part B premium, up to the 1990 premium amount (excluding any special coverage premiums), that you and your eligible Class I dependents who were covered under MEP or MAP on your retirement effective date pay to the government for Part B coverage — unless the Company is providing primary medical coverage. To apply for reimbursement, contact your Benefit Office. If the Company is providing primary coverage, Part B premiums are not reimbursed.

Once you or any of your dependents meet the criteria for Medicare eligibility, MAP will not reimburse any benefits payable under the law regardless of your enrollment status. MAP will subtract any benefits available under Medicare from the MAP benefits you can receive. In combination, Medicare with MAP, will currently provide the same level of

coverage you had under MAP alone. Medicare will be primary except as explained below.

COVERAGE FOR ACTIVE EMPLOYEES ELIGIBLE FOR MEDICARE

If you work beyond age 65, MAP will continue to be primary to Medicare for you and your spouse. If either you or your spouse reject primary coverage under MAP in writing and choose Medicare as your primary coverage, MAP coverage will end for the person making the election — until you retire.

For an active employee who has a disabled dependent (for reasons other than End-Stage Renal Disease), MAP will provide primary coverage for the disabled dependent until he or she reaches age 65. At age 65, Medicare becomes the primary plan for any disabled dependent other than the spouse of an active employee. The disabled spouse's coverage under MAP will remain primary as long as the employee is an active employee.

If a participant requires treatment for End-Stage Renal Disease, MAP will provide primary coverage for the first 12 months but thereafter will be secondary to Medicare.

COVERAGE FOR CLASS II DEPENDENTS

When a Class II dependent age 65 or older is not eligible for Medicare coverage on his or her own work record, the Medicare payments which would have been provided for both Parts A and B will be carved out before any benefits are payable under MAP.

No reimbursement for Part B Medicare premiums will be made for Class II dependents.

* * * * * *

The Company reserves the right to change or modify coverage, including reduction, elimination of coverage, or requiring employees or dependents to pay all or a portion of coverage costs, at its discretion, subject to applicable collective bargaining agreements.

* * * * * *

SECTION 14. HOW TO FILE A CLAIM

WHEN TO APPLY

Once coverage begins, you can apply for benefits as soon as you incur a covered expense. (Separate claims must be filed for each covered dependent.) However, it is recommended, whenever possible, that all requests for benefit payments be submitted to Blue Cross and Blue Shield within 90 days after the medical expenses are incurred. For hospitalization, the hospital and doctor will normally file your claims.

Claims must be filed by the provider or participant no later than 12 months from the date of the service. Claims received after one year from the date the expenses were incurred will not be accepted, covered or paid.

FILING CLAIMS WHEN COB APPLIES

Requests for benefit payments should always be filed first with the primary plan. When COB rules determine MAP is secondary, MAP payments will be delayed until you provide information on your other available group plan coverage. It is your responsibility to keep your and your dependents' enrollment information current on your Company Enrollment Form. If you fail to do so, it may result in delayed, reduced or denied payments.

Retired employees enrolled in Medicare should always file first with Medicare and then attach their Explanation of Medicare Benefits (EOMB) Form and itemized bill to the Medical Plan Claim Form.

HOW TO APPLY

Benefits provided by MAP can be requested using the Medical Plan Claim Form or, if your expense is for prescription drugs, by using the Medical Plan Prescription Drug Claim Form. You can obtain Claim Forms by calling Blue Cross and Blue Shield at 1-800-633-8915. For obtaining prescription drugs through the Mail Order Prescription Drug Program or the PPO pharmacy network, see Section 10.

Follow the instructions for completing the Medical Plan Claim Form and send it along with all itemized bills to Blue Cross and Blue Shield; BellSouth Dedicated Service Center; Post Office Box 830279; Birmingham, Alabama 35283-0279.

Benefit requests should be as complete as possible and must show:

- Employee's/retiree's full name, Social Security Number and Contract Number as shown on the BellSouth Medical Plan Identification Card;
- Spouse's employment and other medical coverage information;
- Full name and Social Security Number of patient;
- Date of service and where provided;
- Diagnosis;
- Type of service;
- Amount of charges; and
- Registration or license number of registered nurse or licensed practical nurse, when applicable.

In addition, bills for prescription drugs covered under MAP should show the prescription number, the National Drug Code, the purchase date and other specific information. Supporting proof of purchase, such as the original or a copy of an itemized bill or receipt, including the pharmacy's